LOS ANGELES COUNTY COMMISSION FOR CHILDREN AND FAMILIES

Dana E. Blackwell
Executive Director

APPROVED MINUTES

The General Meeting of the Commission for Children and Families was held on Monday, **August 15, 2005**, in room 140 of the Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles. **Please note that these minutes are intended as a summary and not as a verbatim transcription of events at this meeting.**

COMMISSIONERS PRESENT (Quorum Established)
Ann E. Franzen
Helen Kleinberg
Daisy Ma
Rev. Cecil L. Murray
Sandra Rudnick
Adelina Sorkin
Dr. Harriette F. Williams
Stacey F. Winkler

COMMISSIONERS ABSENT (Excused/Unexcused)
Carol O. Biondi
Patricia Curry
Joyce Fahey
Dr. La-Doris McClaney

APPROVAL OF THE AGENDA
The agenda for the August 15, 2005, meeting was unanimously approved.

APPROVAL OF MINUTES
The minutes of the August 1, 2005, general meeting were unanimously approved as amended.

CHAIR'S REPORT
- The next Commission meeting is on the Tuesday after Labor Day, September 6.

- The Commission retreat is being tentatively planned for October 17. Chair Williams asked that Commissioners confirm their availability for that date by the end of this week so that an agenda can be planned and a location determined.

- Children's Institute International has changed its name to Children's Institute Incorporated.

- A conference on family violence is taking place in San Diego in September; if Commissioners are interested in attending, their registration can be paid for.

- Initial information on the disbursal of the MacLaren Children's Center funds and the status of the Paramount site has been received from Angela Carter, and a full presentation will be scheduled for the Commission when director David Sanders is available.

- Dana Blackwell met with several youth at The Community College Foundation who may be interested in joining the Commission as youth representatives. If any Commissioner is interested in being part of the recruitment process, or has information on criteria used in the past, please contact her.

OFFICE OF INDEPENDENT REVIEW
Following the discussion of child fatalities at the Commission's July 18 meeting, Commissioners Winkler and Fahey asked the agencies involved in child death review to make presentations.

Department of Children and Family Services: Joan Smith reported on the department's current protocol for investigating child fatalities; Each incident is evaluated for referral to a review by the regional office involved, a full child fatality review, a procedure started two years ago. A full review involves a meeting with the regional administrator, the deputy director for the service area, social workers, mental health service providers, medical personnel, representatives from County Counsel and the Inter-Agency Council on Child Abuse and Neglect (ICAN), and anyone else possessing key information about the case. This group looks at systemic issues that should be changed, and offers support to the workers and supervisors involved.

Based on that review, the coroner's report, and other information that may come to light, a 90-day report is shared with the Board of Supervisors and (now) the Commission. If it seems that abuse or neglect was not the cause of death, but the family has some history with the department, the regional office will also do a 30-day review, a part of the process just now being standardized. (Fatalities of children referred to the department but 'evaluated out' and not served are also tracked.) If potential staff violations are identified, a referral is made to the internal affairs section, which makes recommendations for disciplinary action. All reports go through County Counsel.

Office of Independent Review: A recent motion by Supervisor Molina asked Dr. Sanders to look at the Office of Independent Review (OIR), which evaluates incidents for

the Sheriff's Department, with an eye to replicating that process for the Department of Children and Family Services.

Mike Gennaco, chief attorney for the OIR, explained that the six lawyers in that office currently monitor critical incidents such as deaths or significant assaults in the jails, and major events on patrol. The Sheriff asked the Board of Supervisors to create this office four years ago; a blue ribbon committee selected Mr. Gennaco to head the unit and he recruited other attorneys. OIR staff are independent contractors, not employees of the county, and all have extensive civil rights backgrounds. Their three-year contracts with the Board ensure their access to confidential information. Staff are on-call as incidents occur and shepherds the fact-gathering process from start to finish, using the investigative machinery already existing in the Sheriff's Department. They are there to ensure accountability and look at systems issues, policies, supervisory issues, and also to make certain that in the event of misconduct, internal affairs investigators recommend discipline, further training, or other outcomes. The OIR also studies trends and patterns, using the Sheriff's personnel profile index, and works closely with risk management on claims and lawsuits.

Though some functions of the Sheriff's Department are different from those of DCFS, Mr. Gennaco sees the custodial relationship and responsibilities of those who run the jails as being quite similar. Since current OIR staff are dedicated to the Sheriff's Department, at least two new staff would be needed for any involvement with DCFS, and language capabilities would need to be considered. County Counsel and the Chief Administrative Office would negotiate the contract and confidentiality issues would be addressed by the court, since access to all involved parties, including parents and caregivers, is critical. Currently, quarterly reports on every Sheriff's Department case are made public on the OIR's website, along with annual reports of assessments and recommendations.

Inter-Agency Council on Child Abuse and Neglect: ICAN has been conducting multi-agency child death reviews for 28 years, explained Deanne Tilton Durfee, the organization's executive director. It looks at hundreds of deaths—information received from the coroner's office, not limited to DCFS children—and performs a formal review of approximately 300 suspicious or preventable deaths per year. The ICAN review team includes doctors, lawyers, medical examiners, commissioners from the family court, and representatives from DCFS, Probation, and community child abuse councils, who piece together everything that happened in the child's life. Teams focus on systems and policy change, practice, and preventability, rather than individual personnel or disciplinary issues.

Since 1991, the number of child abuse homicides has fallen from 61 to 35. Most deaths are accidental—a result of shaken-baby syndrome, co-sleeping, the lack of pool fencing, automobile/pedestrian encounters, and fire safety/smoking issues. The majority of children killed accidentally are under the age of a year, and almost all children killed by parents or caretakers are age five or younger. About 26 child suicides occur a year, and ICAN has been studying the reasons for that (alcohol abuse, depression, bullying) and

sending emergency counseling teams into schools following those incidents. It has also formed a domestic violence review team (for when the child is not the intended target but is still killed, or when children are killed to retaliate against a spouse) and a team to study unintentional, preventable injuries such as automobiles backing over children in driveways or car accidents when children were not in car seats.

ICAN has recommended cross-reporting between DCFS and law enforcement so that lags in information flow do not result in tragedies; DCFS has received $2 million to implement the first electronic cross-reporting system in the nation. ICAN also collects data and analyzes trends, which show that public awareness campaigns can be successful: shaken-baby and SIDS deaths are falling significantly. ICAN's 2003 report is available through the Commission office, and its National Center on Child Fatality Review website—http://ICAN-NCFR.org—contains information, articles, and reports of review teams from around the world.

Inspector General: When Victor Greenberg was hired as the first inspector general in 1996, he brought Michael **Watrobski** in as his deputy. Since Mr. Greenberg's departure in 2000 to become a juvenile court commissioner, Mr. **Watrobski** —who previously was with DCFS for 15 years—has managed the office on his own, without even a secretary. Though the office's line item is under the DCFS budget, he reports to the Auditor-Controller's office.

When Mr. **Watrobski** receives notice of a child death from the hotline, he studies the prior and current history of the case and interviews surviving family members, social workers, medical professionals, etc. His reports first go to Dr. Sanders for review and comment—Dr. Sanders has never requested any changes—and then to the Board of Supervisors. (An attorney-general opinion from 1994 limited the inspector general's access to case files for some time, delaying his reports, but that opinion was recently superseded by a blanket minute order.) Though the position is designed to look at systemic rather than personnel issues, Mr. **Watrobski** endeavors to lay out what went wrong in each case and how the department might prevent that in the future, as well as reporting any issues of misconduct or negligence on the part of supervisors or workers.

Once the Board of Supervisors approves or adopts a recommendation, it goes to DCFS and is implemented. However, Mr. **Watrobski** cautioned, any procedure or mandated tool—structured decision-making, for instance—is only as good as the workers using it (or ignoring it, as the case may be). The key is training, but that is difficult for him to track.

Mr. **Watrobski** has explored the OIR model and agrees that it could improve his procedures and better inform everyone involved. Since he is not an attorney, he has been unsure about what he could share, but now feels confident that he can work more closely with the Board of Supervisors and the Commission.

County Counsel: Commissioners Winkler and Fahey, along with Ms. Blackwell, met with County Counsel's Brandon Nichols and Katie Fessler regarding the child death

information discussed at the July 18 meeting. Mr. Nichols said that an acceptable balance had been found between providing information to Commissioners and preventing lawsuits by protecting confidentiality. The department is currently working on summarizing the backlog of cases, which should be forwarded to Commissioners by the end of this week. From now on, they will receive data on a flow basis from the 24-hour reports generated by the hotline, and from subsequent 30-day and 90-day reports. A monthly synopsis of conclusions and lessons learned will also be disseminated.

Summary: A letter from Dr. Sanders to the Board of Supervisors regarding replicating the Office of Independent Review, and information on the meeting regarding child fatality reporting, was included in Commission packets. Given Commissioners' limited volunteer hours, Chair Williams urged everyone to think about what data they wish to receive and how often, what they will do with that information, and what review teams they may wish to be part of. Commissioner Winkler will continue to work with Commissioner Fahey and Ms. Blackwell to address these questions, stressing the importance of the option to participate in other processes.

MEDICAL HUBS

Dr. Charles Sophy said that the establishment of the department's medical hubs was based on a desire to stabilize and standardize health and mental health care for foster children throughout the county at their point of entry into the system. Over the last year and a half, five county medical facilities have agreed to provide expert care around the clock to children in the system who:

- Are being detained
- Need a medical exam, either routinely or as part of an investigation
- Are injured in care
- Have special needs, or need health care planning or a second opinion

The hubs include County/USC's Violence Intervention Program (VIP), Harbor/UCLA Medical Center, Olive View Medical Center, High Desert Health System, and King-Drew Medical Center. A sixth hub, at Childrens Hospital Los Angeles, will provide training for staff and caregivers, forensic evaluations, and mental-health, developmental, dental, and nutritional screenings. Most hubs will be open 24/7; some will function on weekdays and use their own or a local emergency room during off-hours. (In the event King-Drew is closed, cases will be divvied up between Harbor/UCLA and Childrens.)

Although the preference with routine exams is for the child to visit a doctor in the community and develop a continuity of care, the hub option is also available. The second phase of the hub rollout, Dr. Sophy said, is the connection to community providers, with each hub reaching out to local doctors and forming a flexible relationship.

The team decision-making process completed when children's are detained will be dependent on the results of their hub examinations only, when a nurse is not involved on the team, or if the team feels more medical information is needed before placement decisions can be made. Hubs have sole responsibility for connecting with caregivers and

social workers to let them know what care children need, and for following up with community providers. If children are suffering from severe injuries when they are detained, hub staff will arrange for immediate emergency-room attention, but most situations will be handled by hub personnel. Hub staff will accompany children whenever they leave the hub for services.

Commissioner Kleinberg expressed concerns about the initial mental-health assessment done at the hubs, saying that stress and anxiety could skew the results. Dr. Sophy said that the initial assessment was only the first step in the MAT track that all detained children go through, and that staff are sensitive to the dangers of labeling children as mentally ill.

To get caregivers to the hubs, a system of transportation vouchers will be used for six months and then evaluated, since the department knows that travel can be difficult for families, especially if multiple children need care. Regular town hall meetings are planned to track customer satisfaction, and surveys will be administered to caregivers, foster children, and others using the system so the department can track and fix situations as they arise.

D RATE UNIT

Marilyn Sklar explained that the D rate is a special foster-care payment rate for children with high mental-health needs, supplying extra funds for tutors, behaviorists, and other special services. When the D rate is initially assigned, a referral is made to the Department of Mental Health, which uses a contracted provider to do an independent mental health assessment. The child is then re-rated after two years.

In the past, no one has ensured that children are connected to the right services, medications, or schools, so a child's diagnosis seldom changed. Town hall meetings with DMH showed that caregivers throughout the county did not have enough information or support to navigate the system. In April, the department formed a D rate unit of ten evaluators to review every case every six months, making sure that children are getting what they need. DMH provided five medical case workers to the unit, bringing the number of staff to 15.

Evaluation teams of licensed clinicians work with caregivers, schools, social workers, and the child to determine how the child is functioning and to develop three to five attainable goals ~~for the next level of care,~~ in the major areas of eating, sleeping, school work, playing, and expression of sexuality. Teams also look at medication use; nine out of ten children using medication are also D rate cases. (The court receives 800 requests per month to begin or renew psychotropic medication.) When children are psychiatrically hospitalized, a D rate worker—rather than the case-carrying social worker—monitors that hospitalization and navigates their discharge. In addition, as older children age out of the D rate system, an automatic referral to SSI is made for them.

The D rate unit is linking with agencies that have historically provided residential care for children under 12 (a practice now discouraged by the department) to furnish respite care,

in-home counseling, parent education on medications and behavior modification, etc. D rate evaluators have traveled to every regional office to inform line workers about the new process, and training on the D rate structure is also planned for community colleges. A link to the new unit has been placed on the department's website, and more than 2,000 calls and referrals have been received each month since its inception.

Commissioner Kleinberg noted the value of gathering information on education and problems with school districts, citing the struggles of the Education Coordinating Council to address the needs of special-education students. Dr. Sophy promised to build that into the unit's tracking system.

A series of future town hall meetings to get feedback on the performance of the D rate unit is being planned, and Chair Williams asked that the Commission be informed of the dates of those meetings.

PUBLIC COMMENT
There was no request for public comment.

MEETING ADJOURNED